PAYMENT OF MEDICARE BENEFITS IN NEIGHBORING NATIONS: PROBLEMS AND POSSIBLE APPROACHES

A Report Requested By
The Committee on Ways and Means
U.S. House of Representatives
And
The Committee on Finance
U.S. Senate

Department of Health, Education, and Welfare
Social Security Administration
June 1969

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

June 24, 1969

Dear Mr. Chairman:

We are enclosing a report on the question of providing Medicare benefits to entitled persons who are hospitalized in neighboring nations. We are also sending this report to the Chairman of the Committee on Finance.

This report explores the feasibility of reciprocal agreements or arrangements with neighboring nations, as well as other possible approaches in dealing with this matter, and is in response to the request of the Conference Committee on the Social Security Amendments of 1967 (H.R. Report No. 1030, 90th Congress, 1st Session, page 47). Unfortunately, several unavoidable circumstances delayed meetings with the Canadian Government until December 1968, and thus delayed completion of the report.

We trust that this report will bring into focus the major aspects of the question of providing Medicare benefits in neighboring nations and will provide your Committee with sufficient information to evaluate the feasibility of various alternative approaches or to direct further investigations.

Appropriate offices of the Department of State have concurred in this report.

Sincerely,

/S/ ROBERT H. FINCH

Secretary

Honorable Wilbur D. Mills
Chairman, Committee on Ways
and Means
House of Representatives
Washington, D.C. 20515

Enclosure

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Secretary

Honorable Russell B. Long
Chairman, Committee on Finance
United States Senate
Washington, D.C. 20510

Enclosure

Payment of Medicare Benefits in Neighboring Nations: Problems and Possible Approaches

BACKGROUND

The Conference Committee on the Social Security Amendments of 1967 considered Senate Amendment No. 89, which would have provided for benefits under Medicare, to residents of the United States who are otherwise eligible, for up to 20 days of inpatient hospital services furnished in a contiguous country by a hospital located in a city or municipality any part of which is within 50 miles of the border of the continental United States. The benefits would have been in the form of an indemnity to the individual for a portion of the hospital's reasonable charges. In the case of nonemergency services, the amendment would have required that the hospital providing care be the nearest one to the patient's residence suitable to treat his illness. The amendment would also have permitted an emergency to be treated under Medicare if it occurred outside the United States within 50 miles of the border. Under present law, benefits are available under Medicare for care at hospitals outside the United States only in cases of emergency which occur within the United States.

As indicated on page 47 of the Report of the Conference Committee on the Social Security Amendments of 1967, the Senate receded from Amendment No. 89 with the understanding that the

Department of Health, Education, and Welfare and the Department of State would explore and report to the Committee on Ways and Means and to the Committee on Finance concerning "the feasibility of entering into reciprocal agreements and arrangements with neighboring nations designed to make Medicare benefits available to U.S. citizens who receive necessary hospital care in such nations."

The Social Security Administration, on behalf of the Department of Health, Education, and Welfare, with the assistance of various offices of the Department of State has held discussions with representatives of Canada and Mexico and explored the problems and feasibility of entering into some type of agreement or arrangement with one or both of them.

PROBLEMS

Border Residents. The main problem of Medicare beneficiaries living in the United States along the borders of contiguous countries--in particular along the Canadian border--is that some of these persons depend on hospital and other medical facilities across the border, as a normal pattern. Those facilities are often more accessible and more adequate than the closest facilities available in the United States. The restrictions under Medicare against reimbursement for care obtained in such facilities outside the United States, except in cases of emergencies occurring in the United States, cause a very real problem for the border residents who use these facilities before age 65 and would continue to do so afterward except for the restrictions.

Amendment No. 89 would have ameliorated the situations of most, though perhaps not all border residents, and also it would have extended similar treatment to some--though not all--other Medicare beneficiaries who experience the need for treatment in contiguous countries. Any resident of the United States who is entitled to hospital benefits under Medicare would have been entitled to inpatient hospital services under Amendment No. 89 within 50 miles of the Canadian or Mexican borders in cases of emergency. This would have included tourists as well as persons on business or visiting friends and relatives. It would not have covered inpatient services for persons whose need for care arises beyond the 50 mile limit where, for example, some of the popular Canadian recreational areas, parts of the Trans-Canada Highway and some major Canadian and Mexican cities are located. The establishment of any arbitrary line, whether a border or any distance beyond it, is likely to cause some cases to be denied merely by virtue of where they occur.

Other Problem Groups. A number of problems, in addition to that of the border residents, have become evident as a result of the present restrictions on providing Medicare benefits outside the United States. Mention has already been made of persons who travel to or through Canada or Mexico as tourists, to conduct business on a regular or extraordinary basis, or to visit friends or relatives. If they are taken ill or are involved in an accident while there, under present law they must return to the United States

at their own expense in order to receive Medicare benefits. Amendment No. 89 would have helped some, but not all, of these. Similar problems arise, of course, for Medicare beneficiaries who travel elsewhere abroad.

Entitled persons who take up residence in Canada may obtain coverage under the Canadian provincial hospital insurance programs, generally only after they have resided in a Province for three months. Those who take up residence in Mexico--and an increasing number of retired United States citizens are currently doing so in the Mexico City and Guadalajara areas--never will qualify under the Mexican program (except in the unlikely case where they work regularly in covered employment while there). Amendment No. 89 was not designed to help such people.

Conversely, there are sizable numbers of Canadian and Mexican citizens among the approximately 20,000 persons in Canada and 6,500 persons in Mexico who are automatically entitled under the Hospital Insurance program because they have attained age 65 and are entitled to cash OASDI benefits. On July 1, 1967, 3,041 persons living in Canada and 1,266 persons living in Mexico were enrolled in the Supplementary Medical Insurance program. Some of these are United States citizens or former permanent residents, but some are apparently others who were entitled to enroll because they were entitled to Hospital Insurance. Any non-U.S. citizen living in Canada or Mexico who is entitled to Hospital Insurance or is enrolled in Supplementary Medical Insurance may, under present law, obtain benefits by entering

the United States. Amendment No. 89 would not have affected the status of any of these persons because they would still have had to establish that they are residents of the United States before they could obtain care under Medicare outside the United States.

EXPERIENCE UNDER PRESENT LAW

No data are obtainable, at present, on the total number of cases that have occurred in the problem areas that have been described. From time to time, however, typical cases are called to the attention of the Department of State and the Department of Health, Education, and Welfare because of hardships or other factors that are involved.

A recent survey made by the U.S. Embassy in Ottawa of inquiries received by the ten U.S. consular posts in Canada during 1968, showed the following. The posts estimate that they received somewhere between 275 and 350 inquiries from American citizens about hospital care. The largest number of these inquiries were directed to the posts in Vancouver, Montreal, and Toronto, although the locations from which the inquiries were made were not indicated. The posts that asked the age of the inquirers indicated that most seemed to be over age 65. At least 20 of the cases reported were hardship cases in which the intercession of the posts was requested.

By the end of 1968, the Social Security Administration had been contacted by more than 60 hospitals in Canada, 13 of which are over 50 miles from the border including 6 that are over 100

miles. In addition, contact had been made by 5 hospitals in Mexico; 4 along the border and 1 in the Mexico City area. These contacts were for the purposes of either establishing a claim for Medicare benefits or establishing the hospital's accreditation so that a beneficiary's stay might qualify him for benefits in an extended care facility in the United States. About 190 claims originating as a result of care received in Canada had been filed under the present emergency inpatient hospital provisions of which about 30 percent were partially or totally denied. Only 3 claims had been filed involving the emergency provisions in Mexico of which 1 was paid and 2 were pending.

Under Section 21(e) of the Railroad Retirement Act, which provides benefits comparable to Hospital Insurance benefits to qualified railroad retirement beneficiaries in Canada, there were 206 claims through the end of 1968 resulting in payments totaling about $34,000. Benefits under this provision are paid only to the extent that the amount payable exceeds the amount payable for like services provided under Canadian law.

DISCUSSIONS WITH CANADA AND MEXICO

As already indicated, representatives of the Department of Health, Education, and Welfare and the Department of State have held meetings with representatives of Canada and Mexico. The purpose of these meetings was to determine whether there is any interest on the part of the other countries in reciprocity and, if so, in what form. The meetings were also very useful in clarifying the similarities and differences between Medicare and

the hospital and medical care programs of these countries and the effect that these might have on any cooperative efforts. As a result of these meetings, it is clear that there is some interest in reciprocal agreements or arrangements on the part of both countries with the United States, but that the degree of interest and the type of arrangements which interest them differ.

Mexico

Mexico maintains a social security medical care program, through the Mexican Social Security Institute, which is a direct provider of hospital and comprehensive medical services to covered workers, to pensioners under their national pension system, and to the dependents of both. It does not provide care for beneficiaries who are abroad. In 1965, the latest year for which figures are available, there were slightly over 6.7 million persons covered for medical care, of whom only about 135,000 were pensioners. The program is effective for covered persons--representing about 16 percent of the population--throughout Mexico, and care is provided through Government-owned-and-operated facilities or, where these are not available, through private facilities under contract. Where facilities are inadequate to treat a particular case, there are provisions for transporting the individual to more adequate facilities. Covered persons are registered with a facility near their normal residence, and, if care is needed elsewhere, provision is made for verifying entitlement by telegraph. The average cost of a day in the hospital under the program in 1967 was about $27.20.

The Mexican Government representatives, at the outset of the discussions, appeared interested in a bilateral treaty under which their social security program would provide care to U.S. citizens in Mexico in return for the United States providing similar care to Mexican citizens in the United States. They also agreed to consider two more limited approaches which were brought up during the discussions. One of these would be the reciprocal provision of services or payment for services up to the limits of the least comprehensive of the two country programs. The other approach would be reimbursement to the host Government program by the program of the beneficiary's Government for services provided to him (up to the limit of his entitlement) on a reasonable cost or other equitable basis.

From the discussions with Mexico, it was clear that the beneficiaries that would be of primary concern in any agreement or arrangement would be (1) Mexican nationals residing along the border who visit the United States and (2) United States nationals who take up residence in the interior of Mexico. United States citizens who visit the border areas in Mexico normally have ready access to adequate facilities in the United States.

Canada

Two meetings were held with Canadian Government representatives, one with National Government officials and the other, at the invitation of national officials, with representatives of all provincial hospital insurance programs. The second meeting was necessary because the Provincial Governments have direct responsibility for the administration of health insurance, and the National Government would not conclude any international arrangements without assurances of the cooperation of the Provinces.

In Canada, the Hospital Insurance and Diagnostic Services Act, passed in 1957, provides for a cost-sharing arrangement by the National Government with Provinces that enter into agreements to provide certain minimum hospital inpatient and outpatient services. All ten Provinces and the Yukon and Northern Territories participate. All participating programs apply to residents, and most have a minimum residence requirement, which may be as much as three months. Hospital services appear to be available throughout all of Canada, although facilities are somewhat limited in the Maritime Provinces and more so in the Yukon and Northern Territories.

In 1966, Canada enacted the Medical Care Act, which provides for National-Provincial cost sharing when a Province introduces a nonprofit medical care program for residents that conforms to certain other national standards. Implementation has been slow because of fiscal and other difficulties at both the provincial

and national levels. Seven Provinces now have medical care plans. Five of these participate under the Act. As of April 1, 1969, the participating Provinces were British Columbia, Manitoba, Newfoundland, Nova Scotia and Saskatchewan. The two non-participating Provinces which have plans are Alberta and Ontario. Intention to participate has been announced by Alberta, New Brunswick, and Quebec.

The Canadian provincial hospital insurance programs all provide benefits to residents who obtain care outside Canada. Benefits in varying amounts are provided for inpatient emergency, inpatient elective, and outpatient care. Six Provinces indemnify beneficiaries at fixed per diem rates, two Provinces and the two Territories indemnify at rates equivalent to those for similar service provided in their own facilities, and two Provinces indemnify against the full or a major portion of the foreign charges. In most instances, the provincial programs have made special provision for four particular groups of beneficiaries among whom the incidence of obtaining care in the United States is high. These are unmarried mothers, students who go to school in the United States, the dependent wives and children acquired by these students while in the United States, and temporary workers. National officials have indicated that, when the new Medical Care Act is fully implemented, some provision will also be made for reimbursement of reasonable charges for physicians' services to beneficiaries who obtain services in the United States.

Some Canadian provincial programs are encountering some difficulties in providing benefits to residents who obtain care outside of Canada. Some of these problems are related to the four special groups just mentioned. Also, some Provinces have received complaints that their indemnities cover only a relatively small portion of the charges actually incurred in the United States, and their officials are disturbed at the relatively higher charges being levied by hospitals here.

A recent comparison of hospital costs between Canada and the United States, made by the Social Security Administration, showed the following. In 1966, the average per diem cost for patients in public general hospitals in Canada was $C35.74 with averages ranging from about $C27 to about $C44 among the Provinces. The average per diem cost for patients in non-Federal general hospitals in the United States was $45.46, with averages ranging from about $39 to about $56 among various geographic regions. The study also indicates that per diem costs in Canada have been rising faster than in the United States since 1959.

With respect to treating persons from the United States in Canada, some Canadian officials have expressed concern at the number of bad debts that have been incurred by patients from the United States. Despite this problem, however, no person in need of care is turned away. Interest was expressed in any reciprocal arrangement under Medicare or under Medicaid that would help reduce the number of bad debts. It appears that the Medicaid programs of

some of the States along the Canadian border already pay for some services provided in Canada, but only for cash recipients of public assistance who have an emergency or whose normal pattern is to use Canadian facilities, and not for other medically indigent persons.

In light of the problems they encounter, the Canadians have shown an interest in some type of cooperative arrangement that would facilitate the administration of their programs in the United States and have indicated a willingness to assist the United States in administering Medicare for entitled persons in Canada. They have shown particular interest in facilitating the exchange of entitlement information and information about physicians charges. They have also expressed a willingness to give us assurances that standards for providers of services like those required under Medicare are being enforced in Canada and are under continuous review, and that persons entitled to Medicare will be treated on an equal basis with their own beneficiaries.

They have also expressed a willingness to explore cost reimbursement arrangements that would assure that payments made for services to Medicare beneficiaries in Canada would be based on reasonable cost, and have expressed some interest in determining whether a similar arrangement for Canadians obtaining care in the United States might be feasible and might assist them in stretching the effectiveness of their present indemnities. They have stated that, if and when the United States extends Medicare benefits to

entitled persons needing care in Canada, the responsible national and provincial officials would be glad to discuss and work out any necessary and feasible administrative arrangements to facilitate the administration of each country's program on the other's territory.

ALTERNATIVE APPROACHES

Three basic approaches, and a wide variety of variations on each, are possible to meet some or all of the problems mentioned. The three approaches are unilateral extension of benefits to persons abroad, unilateral extension combined with reciprocal arrangements for administration, and reciprocal extension of benefits.

Reciprocal Extension of Benefits

Of these three basic approaches, it would seem that the purely reciprocal extension of benefits would be the least desirable approach because, although it might be feasible in some circumstances, it would require a radical change from the current pattern of the Medicare program, it could result in a highly impractical administrative effort with respect to the extent of the problems that exist for Medicare beneficiaries, and it might nevertheless result in some apparent, if not real, inequities.

Reciprocal extension of benefits would first of all require either ratification of a formal treaty that would become an integral part of domestic law or, alternatively, the enactment of legislative

authority for the Executive Branch to conclude executive agreements, in either case on a bilateral basis. In each treaty or agreement, the quid pro quo would have to take into account the differences in the domestic programs of the contracting parties.

In view of the major differences among the Canadian, Mexican and United States programs that have already been described, it would be necessary either for the United States to offer more favorable treatment to some categories of foreign nationals than it gives to similar domestic categories or, alternatively, to offer less protection to foreign nationals than they are getting at home and, in the case of Canada, less than they are now receiving in the United States under their own program. Medicare in the United States provides benefits only to those aged 65 and over, while under a purely reciprocal extension of benefits, Medicare might also be asked to provide benefits to younger foreign nationals. Based on the discussions with Canada, it is doubtful that the Canadians would be willing to participate in any bilateral treaty, primarily because of the Constitutional problems it would involve for them. It is also doubtful that any realistic basis for a quid pro quo exists between the United States, with a program of relatively limited scope, and other countries with more comprehensive programs.

Unilateral Extension of Benefits

Unilateral extension of benefits to Medicare beneficiaries abroad would also require legislative action. The form that legislation could take would depend first on whether the Congress considers it desirable to take care of only the special problems of border residents, or whether the problems of beneficiaries not otherwise protected in the countries should also be considered.

Border Residents. If the Congress wishes to take care only of the border residents, an approach similar to that of Amendment No. 89 might be suitable. In the light of the previous comments on this approach, however, some modifications to provide somewhat greater protection for the border residents and to make the provisions more clearly limited to this group, might be worth considering.

Other Persons Abroad. A reasonable case might be made for extending at least some Medicare benefits to any entitled person who goes to a contiguous country regardless of where his need for care may arise. Amendment No. 89 recognizes this in respect to residents who go on a temporary basis and require emergency care within a certain geographic area. The rationale for going beyond Amendment No. 89 would be that it might be difficult in some cases to determine who goes on a temporary and who on a permanent basis, and that just as many problems--albeit different ones--might be

generated by drawing an arbitrary line beyond the border as by using the border as a dividing line. Another reason favoring this type of extension might be that it removes some restraints on freedom of movement which is one of the bases of friendly relations between the United States and contiguous countries.

A unilateral extension of a limited amount of Medicare benefits to any entitled person in a contiguous country would probably not be very costly primarily because the numbers of persons involved and needing care would be relatively small. The cost and the administration of such a measure could be carefully controlled if the benefits were paid in the form of a per diem indemnity or actual charges if less, for treatment in a hospital, and if such benefits were limited to payment for care not otherwise provided under the program of the host country by reason of the beneficiary's residence or citizenship there.

Unilateral Extension with Reciprocal Administrative Arrangements

This approach would combine the relative simplicity of the unilateral approach with some additional features intended to protect the interests of Medicare beneficiaries abroad and to obtain the cooperation of the host government, in return for which the United States would offer reciprocity to the program of the host government along the same lines. Under this approach, the unilateral extension of Medicare in the manner already described

to entitled persons in a country would be made contingent on the conclusion of an appropriate bilateral executive agreement with that country to assure proper administration of benefits.

Legislation would first be necessary to authorize extending a specific benefit package to persons in a specific category of countries, such as contiguous countries. Benefits could be extended on an indemnity basis or on a service basis, but in either case it would seem desirable to limit benefits to payment for any services included in the package to the extent that they are not otherwise provided under the program of the host country by reason of the individual's citizenship or residence.

The extension to entitled persons in an authorized country would then expressly be made contingent on the conclusion of appropriate arrangements between the government of that country and the United States to assure equal access to treatment for Medicare beneficiaries with beneficiaries of the host country, to assure that standards for providers of services comparable to those required under Medicare are in force and are under continuous review, to provide for the exchange of such information as is necessary to facilitate the administration of Medicare in the other country, and, if services are provided, to provide a method of reimbursement for these services based on cost or charges or some other equitable basis.

In anticipation of the likelihood that the Government of the other country would condition its willingness to enter into such arrangements on reciprocal arrangements for their own nationals residing or located in the United States, it would be desirable that enabling legislation also authorize the conclusion of appropriate reciprocal arrangements.

As in any form of reciprocal arrangement, this approach would necessitate enlisting the cooperation of providers of services in the United States. It would also involve more administrative complications than a straight indemnity approach without any reciprocal arrangements.

Conclusions

Reciprocal agreements between the United States and neighboring nations which provide for reciprocal treatment of each other's beneficiaries under their respective medical care programs do not appear feasible at the present time. Unilateral extension of Medicare does, however, appear to be feasible. If desired, unilateral extension could be limited to Medicare beneficiaries who are border residents or could apply to Medicare beneficiaries anywhere in contiguous countries. Unilateral extension could be accomplished with or without reciprocal administrative arrangements.